ECFC WRITTEN MEDICATION CONSENT FORM

Erwin Child & Family Center
A community of learning and caring.

One form must be completed for each medication.
Multiple medications ***can not*** be listed on one consent form.

LICENSED AUTHORIZED PRESCRIBER must complete #1 - #16
See section #29 - #34 on back for chronic conditions or changes to previous medication orders

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength):	5. Amount/dosage to be given:	6. Route of administration:

7A. Frequency to be administered (i.e. 3-X Daily, every 4-6 hours, etc.):
AND FOR SYMPTOMATIC MEDICATION:
7B. Identify the symptoms that will necessitate administration of medication: Signs and symptoms must be observable and, when possible, measurable parameters. (i.e. fever greater than 100°)

8. Date to be discontinued or length of time in days to be given (Maximum of 6 months from the date authorized):

9A. Possible side effects: ☐ See package insert for complete list of possible side effects (parent must supply)
AND/OR
9B. Additional side effects:

10. What action should the child care provider take if side effects are noted (check all that apply):
☒ Contact parent (ECFC Policy) ☐ Contact prescriber at number provided below
☐ Other (describe):

11A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)
AND/OR
11B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe any situations when medication should not be administered):

12. Reason the child is taking the medication (unless confidential by law):

13. Prescriber's name (please print):	14. Prescriber's telephone number:
15.Licensed authorized prescriber's signature: **X**	16. Date authorized:

PARENT/GUARDIAN must complete #17 - #20

17. I, _____ (please print), parent/legal guardian, authorize the day care program to administer the medication as specified in the "Licensed Authorized Prescriber Section" to the above named child.

18. Parent or legal guardian's signature: **X**	19. Date authorized:

20. Fill out #20 ONLY for medication that requires administration at a specified frequency and thus at a specific time. (i.e. Prescribed for 3 times daily):

Please write the specific time(s) the day care program is to administer the medication:

_____

ECFC WRITTEN MEDICATION CONSENT FORM

DAY CARE PROGRAM to complete #21 - #26

21. Provider/Facility name: **Pathways, Erwin Child & Family Ctr**	22. Facility ID number: **00044051DCC**	23. Facility telephone number: **607-962-0536**
I have verified that #1 - #20 and if applicable, #29 - #34 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.		
24. Authorized child care provider's name (please print):	25. Date received from parent:	
26. Authorized child care provider's signature: **X**		

Only complete #27 - #28 if the PARENT REQUESTS TO DISCONTINUE the medication prior to the date indicated in #8

27. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

28. Parent or Legal Guardian's Signature:
X

LICENSED AUTHORIZED PRESCRIBER to complete #29 - #34, AS NEEDED

29. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?
☐Yes ☐No If you checked yes, complete #30-#31 below.

30. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

_____

_____

31. Licensed Authorized Prescriber's Signature:
X

32. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?
☐Yes ☐No If you checked yes, complete #33 - #34 below.

33. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order.

DATE:_____

By completing this section the day care program will follow the written instruction on this form and not follow the pharmacy label until the new prescription has been filled.

34. Licensed Authorized Prescriber's Signature:
X